CALIFORNIA MEDICAL ASSISTANCE COMMISSION
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CALIFORNIA MEDICAL ASSISTANCE COMMISSION

State Capitol, Room 112

Sacramento, CA

Minutes of Meeting

September 23, 2004

COMMISSIONERS PRESENT
Nancy E. McFadden, Chair
Thomas Calderon
Diane M. Griffiths
Teresa P. Hughes
Vicki Marti
Lynn Schenk
Michael R. Yamaki

CMAC STAFF PRESENT
J. Keith Berger, Executive Director
Enid Barnes
Theresa Bueno
Paul Cerles
Denise DeTrano
Holland Golec
Mervin Tamai
Karen Thalhammer

EX-OFFICIO MEMBERS PRESENT
Kirk Feely, Department of Finance
Sunni Burns/Stan Rosenstein, Department of Health Services

I. Call to Order

The September 23, 2004 open session meeting of the California Medical Assistance Commission (CMAC) was called to order by Chair Nancy E. McFadden. A quorum was present.

II. Approval of Minutes

The September 9, 2004 meeting minutes were approved as prepared by CMAC staff.

III. Executive Director's Report

The Executive Director, Keith Berger, reported that there were three requests by hospitals to appear before the Commission in closed session. He indicated that Good Samaritan Hospital of Los Angeles and Regional Medical Center San Jose had representatives present and recommended that the Commission approve their requests to appear in today's closed session. The motion was unanimously approved.

Mr. Berger informed the Commissioners that Children's Hospital of San Diego has also requested to appear in closed session before the Commission. The Executive Director recommended that the Commission approve their appearance at the October 7 meeting. The motion was unanimously approved.

Mr. Berger indicated that CMAC staff is moving forward with SB 1255's Round 17A. He stated that 77 hospitals have returned their Intent to Participate forms and their proposals. CMAC staff is reviewing those documents and preparing to begin negotiations.

With regard to the Selective Provider Contracting Program (SPCP) waiver, Mr. Berger reported that the Department of Health Services (DHS) has submitted a letter to the Centers for Medicare & Medicaid Services (CMS) requesting a six-month extension. The extension will give the state a chance to work through some of the issues associated with the efforts to revise the Medi-Cal hospital financing system. The intent is to request a new five-year, 1115 waiver that will combine the current SPCP and Los Angeles County (LA) waivers.

Stan Rosenstein, DHS, Deputy Director Medical Care Services, reported that a draft summary of California's proposal for a new section 1115 waiver had been sent to hospitals and legislative staff to review and comment on the document. Copies were also provided to the Commission. Mr. Rosenstein stated that the Department would like to finalize the document by September 24, 2004.

Mr. Rosenstein informed the Commission that he, Agency Secretary Kimberly Belshé, and DHS Director Sandra Shewry will be going to Washington D.C. to meet with Dr. Mark McClellan, CMS Administrator, and Dennis Smith, Director of Medicaid, on Tuesday, September 28, to discuss the proposal.

Mr. Rosenstein reported that CMS is asking California, along with other states, to begin phasing-out certain intergovernmental transfer (IGT) programs. He further reported that he hoped that the proposal for a five-year waiver will provide the SPCP with a more stable funding source, instead of having to renew the SPCP waiver every two years. DHS is requesting not only federal funding at the current level but enough funding and flexibility to cover growth as well as unforeseen circumstances.

Mr. Rosenstein discussed a few key goals identified in the draft proposal: preserving the current levels of federal and non-federal contributions to the SPCP,

providing a secure, five-year financing package, and confirming the State's ability to access its full federal Disproportionate Share Hospital (DSH) allotment.

To achieve these goals, the proposal envisions:

1. Continuation of the SPCP.
2. Expansion of Medi-Cal to incorporate, by waiver, the public indigent care system currently operated in Los Angeles County and many other counties throughout the State.
3. Modification of the basis for hospital reimbursement to utilize Certified Public Expenditures (CPE) as the primary means of funding fee-for-service and DSH payments to public, safety-net hospitals, with the continued use of some "protected" IGT's considered permissible by CMS.
4. Continuation of the current upper payment limit, notwithstanding shifts in service delivery from fee-for-service to managed care.
5. Flexibility in financing to accommodate whatever changes in the Medi-Cal delivery system emerge from the current and ongoing Medi-Cal redesign efforts.
6. Opportunities for program growth during the waiver period.

Mr. Berger added that once the conceptual proposal has been reviewed by CMS, over the coming months there will be time to refine the details of the proposal. He also added that the draft proposal states that the SPCP waiver has been in place for more than 20 years, and it is appropriate to move the SPCP to a five-year waiver.

IV. Medi-Cal Managed Care Activities

Paul Cerles, CMAC Supervising Negotiator, reported that CMAC staff has been working on a number of rate amendments that were discussed at the last Commission meeting. He further reported that he has been in discussions with DHS on the rate process in order to make it easier and more orderly so that CMAC can move forward with the contracts on a timely basis. As for the Sacramento GMC Medical and Dental programs, DHS is moving forward with the request for application (RFA) process and should have available a list of eligible plans by the end of the month so that CMAC staff can begin negotiations for new contracts effective by the first of the year.

In concluding his report, Mr. Cerles informed the Commission that due to workload issues with the DHS actuaries, CMAC does not have new rates for the medical plans to negotiate new contracts with CMAC at this time.

V. Presentation by California Healthcare Association (CHA)

Sherreta Lane, Vice President of Reimbursement and Economic Analysis, informed the Commission that CHA represents 500 member hospitals and health

systems. CHA feels that access to care is being jeopardized and that this is especially evident by the recent hospital closures--six hospitals in Los Angeles County, one in San Jose, and another hospital that is announcing its closure today.

Ms. Lane stated that each time a hospital or emergency department or trauma center closes there is a domino effect. The patients that were being seen in the closing facilities are pushed out to other facilities that are already overcrowded and are facing financial challenges of their own. The reasons for the closures are financial. She said California hospitals are mired in a wasteland of unfunded mandates, such as nurse staffing ratios, and poor reimbursement, and a number of other factors affecting their bottom line. She noted that hospitals employ more than 400,000 people in California. Compensation, wages and benefits are a significant driver of increased costs to hospitals, and nearly three-fifths of the hospitals' costs go to wages and benefits.

Capital costs are also a concern. SB 1953, the seismic safety mandate, requires hospitals to comply with certain life/safety structural and additional nonstructural requirements by 2008. The original cost estimates for SB 1953 were at least $14 billion to bring hospitals in to compliance. However, the RAND corporation recently estimated that the cost will be $41 billion, without financing costs.

Ms. Lane pointed out that new medical technology improves the quality of health care, but it comes with a price. Payments to hospitals by public and private payers are not keeping pace. In addition, in 2003 California hospitals provided over $5 billion in uncompensated care to low-income and uninsured patients, while Los Angeles County reported that it spends approximately $340 million per year on emergency and follow-up health care for undocumented immigrants.

In conclusion, Ms. Lane urged CMAC to carefully consider the financial pressures that California hospitals are facing. The closure of eight hospitals in nine months is not insignificant she said, with more yet to come.

Commissioner Griffiths indicated that part of the problem with California is that California is reimbursed less money per patient from CMS than other states. Commissioner Griffiths questioned whether there will be any efforts made federally to try to remedy this problem.

Ms. Lane responded that there are efforts in Washington to increase the Medicaid match for several states, including California.

Mr. Rosenstein added that the Government Accountability Office (GAO) did a study at the request of Senator Feinstein. The GAO study found a flaw in the calculations of the Medicaid federal match rate that substantially disadvantages California. It is a flaw in federal law and the Senator had proposed legislation to give the states a choice of two Federal Medical Assistance Percentage (FMAP) methods. The legislation was not successful as it was opposed by many states that would have had their present FMAP decreased.

Chair McFadden asked if this FMAP inequity issue was on the radar screen of the administration, including the Governor's Office, and how much of a concerted effort there is to actually deal with correcting this issue.

Mr. Rosenstein indicated that the administration would support a nationwide FMAP equity adjustment if there was a possibility that it could occur, but every signal the State has received is that it has no life in Congress, and that there are better opportunities to seek additional federal funds.

In response to Commissioner Griffiths' question regarding additional funding if the waiver proposal is accepted, Mr. Rosenstein indicated that if the State goes with the regular SPCP waiver renewal, the State would see a cut in revenue, which is what DHS wants to prevent. The new proposal is to provide for planned revenue growth and the ability to address unforeseen circumstances.

VI. New Business/Public Comments/Adjournment

There being no further new business and no additional comments from the public, Chair Nancy E. McFadden recessed the open session. Chair McFadden opened the closed session, and after closed session items were addressed, adjourned the closed session, at which time the Commission reconvened in open session. Chair McFadden announced that the Commission had addressed hospital contract negotiation issues in closed session.